insurance entities. The purpose of this system and method is to examine the medical treatment claims to determine whether these submitted claims appear to be fraudulent. A clearing house is provided for receiving the information from the plurality of practitioners. The clearing house includes software for examining the claims based upon several criteria. Software is provided with a memory containing a recognizable number of ICD9 diagnostic codes as well as a plurality of recognizable CPT treatment codes. An algorithm is provided in the software looking at a particular examination/ treatment period of time (such as 15 minutes, one-half hour, 1 hour, etc.) for the purpose of determining whether inconsistent disparate medical treatment claims have been claimed for that examination/treatment period. For example, if the medical practitioner was a podiatrist and the podiatrist presented a claim for a single examination/treatment period for excising a wart as well as treating a strep throat, the software would recognize these two treatments as being incompatible and would set it aside for manual review. Additionally, the algorithm would recognize whether it would be possible for two different procedures being performed during a single examination/treatment time.

Furthermore, the system and method according to the present invention would maintain all of the claims submitted by the practitioner in a memory for a particular period of time. Therefore, if the practitioner would submit a second claim for a time period to which the practitioner has already submitted a claim, this second claim would also be flagged. In this case, the potential for fraud would be noted by the system and method, according to the teaching of the present invention, regardless of whether the single practitioner submitted the second claim for the same patient that the practitioner submitted for the first claim, or for different patients for both claims.

The Examiner has rejected claims 1, 2, 6, 7, 9, 10, 13-15, 19 and 21 under 35 U.S.C. Section 102(e) as being

anticipated by the patent to Peterson et al. This rejection is respectfully traversed.

The patent to Peterson et al is directed to a claims processing system provided with a central system for the adjudication and payment of medical claims. The central system would allow a medical practitioner who submitted a claim to be paid if certain criteria are met. An automatic/manual adjudication system would be used to review the submitted claim. One of the main thrusts of this system would be to determine whether an automatic or manual adjudication would be used to review the claims. Although one of the criteria used to determine whether the claim would be manually or automatically reviewed is an unbundling check shown in Step 86 and described in column 10, lines 8-27, the purpose of this unbundling step would be to determine whether the practitioner billed for separate procedures even though a single incision was made. While the determination that a single procedure would be submitted instead of multiple procedures would alter the amount paid to the medical practitioner, this is not the type of fraudulent activity that the present invention is designed to combat.

Applicant has amended independent claims 1 and 13 by specifically indicating that the clearing house would review each of the claims submitted by a single practitioner to determine whether that practitioner has submitted more than one disparate medical treatment claim for a single period of time on a single day. Furthermore, applicant has added new claims 22 and 23 reciting a system or method in which more than one disparate medical claim for a single period of time on a single day claims treatment to different patients. It is believed that independent claims 1 and 13 are not anticipated or suggested by the Peterson et al patent. Furthermore, since all of the claims now in this application directly or indirectly depend from these two independent claims, it is believed that all of the claims define over the prior art of record. Therefore, reconsideration and allowance of these claims are earnestly solicited.

The Examiner has rejected claims 3 and 16 under 35 U.S.C. Section 103(a) as being unpatentable over the Peterson reference in favor of the reference to Boyer. These rejections are respectfully traversed.

The patent to Boyer is directed to a point of service third party health care management system which includes an adjudication engine for determining eligibility of a submitted claim. It is noted that the adjudication engine normally operates on real time. Additionally, each third party payor is provided with a separate adjudication engine since the rules of eligibility as well as the cost involved for a particular examination or treatment would be unique to each of the third party payors. Therefore, the teaching of the Boyer patent would not be directed to preventing the type of fraud described and claimed in the present application. The adjudication engine of Boyer is directed to the patient and not to the medical practitioner for a determination of whether the patient has abided by the rules of their respective policies. For example, as described in the column 14, lines 54-67, the adjudication process would include verifying eligibility such as whether dental coverage is provided or whether timing constraints were met such as one wellcare visit per year. It is noted that claims 3 and 16 have been cancelled and the subject matter contained therein has been subsumed into claims 1 and 13. This additional language in claims 1 and 13 would indicate that the single period of time would be during a single day. It is believed that claims 1 and 13, as well as all of the claims dependent therefrom, are not anticipated by any combination of the Peterson and Boyer patents. Therefore, reconsideration and withdrawal of this rejection are respectfully urged.

The Examiner has rejected claims 4, 5, 17 and 18 under 35 U.S.C. Section 103(a) as being unpatentable over Peterson in view of the patent to Pendelton. This rejection is respectfully traversed.

Claims 4, 5, 17 and 18 are directed to a system or method in which the clearing house would review the appropriateness of each treatment claim based upon the total number of claim hours submitted for a particular duration of time. The system described in the Pendleton patent describes an expert system used to analyze provider records to determine whether a "pattern" of numerous and expensive procedures are submitted. However, it is noted that claims 4, 5, 17 and 18 depend from independent claims 1 and 13 and for the reasons enumerated hereinabove, it believed that these claims would also recite patentable subject matter. Reconsideration and allowance of these claims is therefore earnestly solicited.

The Examiner has rejected claims 8 and 10 under 35 U.S.C. Section 103(a) as being unpatentable over Peterson in view of the patent to Holloway et al. These rejections are respectfully traversed.

Claims 8 and 20 are directed to a method or system wherein a reviewing step includes comparing more than one treatment code included in the treatment claim with another treatment code. The patent to Holloway does not concern itself with a system in which a particular examination/treatment would be examined. Therefore, for the reasons enunciated hereinabove, it is believed that since claims 8 and 20 depend from either independent claims 1 or 13, these claims also recite patentable subject matter.

The Examiner has rejected the remaining claims in this application over the patents to Moore or Provost. These rejections are respectfully traversed.

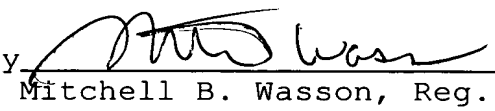
Since these claims are dependent from independent claims 1 and 13, it is believed that these claims also recite patentable subject matter and should be allowed.

The remaining references relate to software used generally to combat medical claim submission fraud. However, none of these references describe a situation in which the claims of a particular practitioner are examined for a particular

examination/treatment time. Therefore, it is believed that the claims present in this application are not anticipated or suggested by any of these claims.

It is believed that all of the claims now in this application define over the prior art. Consequently, reconsideration and allowance of this application are earnestly solicited.

Respectfully submitted,

by 
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Marked-Up Set of Claims

WE CLAIM:

1. (Amended) A system for reviewing medical treatment claims provided by a plurality of practitioners to a plurality of insurance entities for the determination of the appropriateness of the medical treatment claims provided to a plurality of patients, comprising:

a clearing house for receiving information from the plurality of practitioners regarding claims to be paid by one or more of the plurality of insurance entities, said clearing house provided with software to determine the appropriateness of each of the claims submitted by each of the plurality of practitioners, wherein said software determines the appropriateness of each of the medical treatment claims based upon whether a single practitioner has submitted more than one disparate medical treatment claim for a single period of time on a single day, said clearing house communicating with the plurality of insurance entities and the plurality of practitioners regarding the appropriateness of each of the claims.

2. The system in accordance with claim 1, wherein said clearing house pays the proper practitioner once said clearing house has determined that a particular claim submitted by that practitioner to said clearing house is appropriate.

3. Cancelled

4. The system in accordance with claim 1, wherein said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time.

5. The system in accordance with claim 4, wherein said particular duration of time is one work day.

6. The system in accordance with claim 1, wherein said clearing house is provided with a memory containing a list of treatment codes and a list of diagnostic codes.

7. The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based reviewing a treatment code with respect to a diagnostic code for a particular patient.

8. The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive.

9. The system in accordance with claim 2, wherein said clearing house is paid by the appropriate insurance entity when said clearing house pays the proper practitioner.

10. The system in accordance with claim 1, further including a device for entering data provided at each of the practitioner locations.

11. The system in accordance with claim 10, wherein said device includes a bar code reader.

12. The system in accordance with claim 10, wherein said device includes a keyboard.

13. (Amended) A method of determining the appropriateness of a treatment claim submitted by one of a plurality of practitioners to one of a plurality of insurance entities, the claimed treatment claim covering a treatment prescribed to a patient based upon a particular diagnosis or condition, comprising the steps of:

establishing a clearing house for examining each of the treatment claims;

submitting [one or more] treatment claims to said clearing house;

reviewing each of the treatment claims to determine the appropriateness of each of the [treatments] treatment claims, said reviewing step including determining whether a single practitioner has submitted more than one disparate medical treatment claim for a single period of time during a single day; and

communicating with the appropriate practitioner and the appropriate insurance entity the appropriateness of each of said treatment claims.

14. The method in accordance with claim 13, including the step of having said clearing house pay the practitioner if said reviewing step indicates that a particular submitted treatment claim was appropriate.

15. The method in accordance with claim 14, including the step of having one of the insurance entities pay said clearing house if said reviewing step indicates that a particular submitted treatment claim was appropriate.

16. Cancelled

17. The method in accordance with claim 13, wherein said reviewing step determines the appropriateness of each treatment claim based upon the total number of claim hours submitted for a particular duration of time.

18. The method in accordance with claim 17, wherein said duration of time is a work day.

19. The method in accordance with claim 13, wherein said reviewing step includes comparing a treatment code included in said treatment claim with a diagnosis code included in said treatment claim.

20. The method in accordance with claim 13, wherein said reviewing step includes comparing more than one treatment code included in said treatment claim with one another.

21. The method in accordance with claim 13, further including the step of obtaining a pre-authorization from one of th insurance entities for the treatment covered by said treatment claim.

22. (New) The system in accordance with claim 1, wherein said more than one disparate medical claim for a single period of time on a single day claims treatment to different patients.

23. (New) The method in accordance with claim 13, further including the step of determining whether a single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day.